Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 18, 2013	2013_182128_0027	L-000683-13	Complaint

Licensee/Titulaire de permis

DIVERSICARE VI LIMITED PARTNERSHIP
458 Glencairn Avenue, TORONTO, ON, M5N-1V7

Long-Term Care Home/Foyer de soins de longue durée

CHELSEY PARK (OXFORD) NURSING HOME
310 OXFORD STREET WEST, LONDON, ON, N6H-4N6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

RUTH HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 2 & 3, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, 1 Nursing Operations Supervisor, 1 Clinical Care Coordinator, Education Manager, 5 Registered Nurses, 3 Registered Practical Nurses, 12 Personal Support Workers/Health Care Aides, Housekeeping, Laundry and Safety Manager, 1 Housekeeping Aide, and 1 Dietary Aide.

During the course of the inspection, the inspector(s) reviewed clinical records for identified residents, observed the tub and shower rooms on one floor, observed care provided to residents and staff/resident interactions, reviewed applicable policies and procedures related to infection control and outbreak management.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident, exhibiting altered skin integrity, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A clinical record review, for an identified resident, revealed that he/she was not assessed, using a clinically appropriate assessment instrument, after developing skin integrity issues. The resident had skin integrity concerns for 40 days.
Two Registered Nurses acknowledged that the resident was not assessed using a clinically appropriate assessment tool as per the home's expectations. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that each resident exhibiting altered skin integrity is reassessed at least weekly.
There was no documented evidence to support that weekly skin assessments were completed for an identified resident who had skin integrity concerns for 40 days.
Two Registered Nurses acknowledged that the resident was not reassessed, at least weekly, as per the home's expectations. [s. 50. (2) (b) (iv)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented for cleaning of the home, including floors.

A tour of the second floor tub room, on October 2, 2013, revealed that the floor was soiled, stained and had a build up of dirt near the door.
The Housekeeping, Laundry & Safety Manager acknowledged that the floor was not clean and that the expectation is that everything in the home is kept clean.
The Administrator indicated that the floor is difficult to clean and that there is a plan in place to renovate the second floor tub room, including floor replacement. The renovation is expected to be completed in 35-45 days. [s. 87. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are procedures in place for preventive and remedial maintenance.

Observation of the second floor tub room, on October 2, 2013, revealed that the floor was damaged with approximately 1/2 inch cracks in it, around the exterior of the room, near the wall, on 3 sides of the room. The door was damaged and had paint chipped off of it and the ceiling was noted to be cracked with some patched areas.
The Housekeeping, Laundry and Safety Manager acknowledged that the home had just done an audit and had identified that the tub room floor and ceiling were damaged and required painting.
The Administrator indicated that the home has a plan in place to renovate the tub room, including the floor and walls. The renovation is expected to be completed in 35 - 45 days. [s. 90. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all drugs are stored in an area or medication cart that is secure and locked.

An unlocked and unattended treatment cart, containing presciption creams was observed, on October 2, 2013. The cart remained unlocked and unattended for 10 minutes.
A registered nursing staff member acknowledged that the expectation is that the cart is to be kept locked when it is not in use and/or it should be locked in the clean utility room. [s. 129. (1)]

2. Another unlocked and unattended treatment cart was observed later in the day, October 2, 2013.
A registered nursing staff member confirmed that the cart was unlocked and unattended and the expectation is that carts containing prescription creams are to be locked away at all times.
The Director of Resident Care acknowledged that treatment carts are expected to be locked when unattended. [s. 129. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection control program related to labelling of personal care items.

Infection control risks related to unlabelled personal care items that had the potential for communal use were observed in the second floor tub room, October 2, 2013.
An unlabelled care caddie, containing the following unlabelled items - hair brush, denture cup, stick deodorant, deodorant spray, toothpaste, toothbrush, 2 pairs of nail clippers, and a razor, was observed sitting on a linen cart in the room.
Another pair of unlabelled nail clippers and an unlabelled nail file were observed sitting on top of the paper towel dispenser.
A Personal Support Worker and a registered nursing staff member indicated that these items were not intended for communal use and should not have been found in the tub room. [s. 229. (4)]

Issued on this 18th day of October, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

RUTH HILDEBRAND